TOPIC 3

COST RECOVERY'S IMPACT ON QUALITY, ACCESS AND EQUITY

TOPIC 3. COST RECOVERY'S IMPACT ON QUALITY, ACCESS AND EQUITY

An ample supply of essential medicines for common illnesses and vaccines for childhood immunizable diseases is one of the first quality improvements sought by Africans and their ministries of health (MOHs). They also want reliable stocks of other medical supplies and equipment — and well-trained, skilled, and understanding health workers to dispense them — in neat, clean health facilities, with vehicles for emergency and outreach transportation.

The term *access*, used to refer broadly to *availability* of health services, has both financial and geographic aspects. The term *equity* also has several dimensions but usually refers to *comparable access* to health services for all population groups.

Policy goals for equity and access are often linked. They involve efforts not only to make health services available to the whole population, but also to remove barriers that may prevent the poor in cities and isolated rural areas, and high-risk groups, from using health services they need. Public health policies in sub-Saharan African countries thus usually include goals for expanding access to basic health services to make them equally available for everyone. Accessibility is often measured by the presence of at least primary health care services within 5 kilometers of people's homes. Mobile or outreach health services are often used to reach this goal.

Policies for improving access often emphasize availability of health services that cut illness and death among high-risk groups such as women and children and people constantly exposed to malaria and communicable diseases such as tuberculosis. Similarly, policies for improving equity commonly focus on removing financial or geographic handicaps in access between urban and rural areas, for example, and between poor and wealthy households.

Cost recovery has been the main policy reform chosen by African ministries of health for financing quality, access, and equity improvements in health service delivery. Cost recovery reforms can capture new funds to:

> pay for quality improvements such as assuring reliable supplies of therapeutic drugs and medical necessities

> improve geographic access to health care services by providing villages with additional outreach services, mobile vaccination teams, or health workers

> improve equity by asking patients who can pay for health services at the time they use them to do so, thus reserving public funds for paying part or all of the cost of services for patients less able to pay

> improve financial access with fee exemptions or reductions for selected health services or for poor or high-risk population groups.

Complementary financing reforms that reallocate resources and encourage private sector participation can multiply cost recovery's contribution to quality, access, and equity. These complementary efforts can help make more cost-effective services available to more people, especially the underserved rural and urban poor. Because African ministries of health have focused on user fees and related cost recovery initiatives, whether these reforms live up to their promise can be judged from their experience and a body of research. Less is known about the relatively untested potential of resource reallocation or private sector development activities for improving quality, access, and equity.

Topic 3 attempts to answer some of the questions policy makers and program managers most commonly ask about controversial aspects of cost recovery and its potential effects on policies to improve quality, access, and equity of health care delivery.

QUESTION 9: What role does quality play in health financing reform?

IN BRIEF: Improving quality is a two-way street. People will pay reasonable fees for recognizably high-quality health care, and their fees generate revenues to help cover the costs of quality improvements. Cost recovery reforms are most likely to work when fee revenues are ploughed back into the delivery system to improve quality. Thus, the link works both ways: quality improvements generate support for financing reform and financing reform can generate the revenues to sustain quality improvements.

Are fees the main influence on people's willingness to pay for health services?

No. Time and travel costs, perceived quality and benefit of a health service, income, and education all enter into a person's decision to pay for health care through a particular provider, or to do without. (*See Question 4)* Perceived quality, however, often predominates over every other factor.[2,6,9,10,18,19,21,22]

Perceived quality, the quality of health care as patients see it, has many dimensions, including health workers' attitude, waiting time, and the appearance of the health facility. In sub-Saharan Africa, patients consider medicine availability the touchstone of health service quality, and they are overwhelmingly willing to pay for medicines.[1,9,21,33,38,42] Thus, ministries of health have frequently concentrated cost recovery initiatives on introducing fees for drugs. Those fees go into revolving drug funds to assure availability of medicines, thereby improving a key indicator of quality from the patient's point of view.

How do quality and fees affect use of health care services?

The positive effects of quality can offset the negative effects of price, according to a growing body of evidence on the impact of fees on people's use of health services in Africa — and elsewhere. These studies show that assessments of fee impact on use are likely to be misleading or inconclusive if they do not take into account whether or not quality is simultaneously improved when fees are introduced or increased.

> Use decreases when quality worsens and increases when quality improves, with few exceptions, as shown in a recent survey of more than 50 user fee experiences in Africa.[36] In Ghana, Zaire, and Mozambique, for example, utilization dropped in rural health units after fees were increased. However, a major part of the revenue collected went to the central treasury, and little improvement was made in local services.[27]

> In Cameroon, Gambia, Niger, Sierra Leone, Sudan, and Zaire, expanded supply and improved quality more than offset price effects of user fees, resulting in net increases in utilization of health services.[5,7,9,21,28,29]

> In Niger, quality outweighs price in decisions to seek or forego health care, according to a pilot test of health financing reforms. Moreover, the poor respond more strongly than the better-off to quality improvements. [8,9,44]

> In Ghana, quality improvements in drug availability, services, and infrastructure could raise attendance at public facilities and lower self-treatment by 15 percent. Fee increases deter consumers from seeking care less than either quality or distance from a health facility.[18]

> In Nigeria, quality influences people's use of health services more strongly than price, and the negative effect of price increases can be offset by higher quality. Public facilities could raise outpatient fees to the private level and still increase use if they offered comparable drug availability and physical surroundings.[39]

QUESTION 10: Have fee revenues been used to pay for quality improvements?

IN BRIEF: User fee revenues retained at the facility level have been widely used to make several kinds of quality improvements. How consistently or well this is done depends on a variety of implementation factors, but especially on the extent to which health personnel are given the authority and the motivation to make improvements.

How have fee revenues been used?

While there are both successes and failures, cost recovery can generate enough money to improve both quality and overall financial sustainability.

> In Benin, user fee revenues have been used to improve drug stocks and to hire new village health workers to extend services to people with limited access to health care.[15]

> In 15 countries, that allow revenue retention at the facility level, fee revenues were used to improve drug supply (9 countries), staff morale (8 countries), equipment (5 countries), and maintenance (7 countries), and to reduce patient waiting time (5 countries), according to a recent worldwide cost recovery survey of ministries of health.[26]

> Under the Bamako Initiative in Nigeria, the Congo, Kenya, and Guinea, health center fee revenues are being used for drugs (37–53 percent), supplies (2–12 percent), personnel incentives (12–48 percent), miscellaneous operating costs (2–12 percent), and savings (8–26 percent).[30]

How important to quality improvement is local management of funds?

There is a general consensus that cost recovery initiatives are more likely to lead to quality improvements when the ability and the incentive to make improvements are given to the health facilities that collect the fees. These conditions are usually achieved when revenues are retained at the facility level, not turned over entirely to the national treasury, and are managed in some decentralized fashion.[4,13,26,27,31,38] Local control of cost recovery revenues becomes more and more a possibility with increasing efforts to decentralize planning, budgeting and service delivery decisions across the continent. Decentralization efforts are in progress in the health sectors in Botswana, Ghana, Lesotho, Tanzania, Zaire, and Zimbabwe, have begun in Benin, Guinea, Mali, and Nigeria, and are being tested in Burundi and Senegal.[27]

> Health facilities in 18 out of 26 countries recently surveyed were allowed to keep revenues from fees, although retention was not always permitted at every level of the health system, and not all of it could always be kept at the facility level. Of the 18 where fee retention was permitted, 7 are in Africa (Cameroon, Ghana, Kenya, Sudan, Tanzania, Uganda, and Zambia), 2 in the Middle East, 5 in Latin America, and 4 in South Asia.[26]

> In another survey, 9 out of 10 cases where improvements were cited, at least part of the user fee revenue was retained and managed locally. On the other hand, in 3 out of 10 cases where fee revenues were managed by facilities or by local health committees, quality was reported as staying the same.[36]

The latter finding suggests that decentralized local management is one but not the only condition for quality improvement. Local management of revenues can be subject to abuse without appropriate community, legal, and other safeguards. In addition, health facilities in the poorest areas or serving dispersed populations may not be able to raise enough revenue to improve quality. In these cases, it may be necessary to establish a mechanism at the district level, such as a *solidarity fund*, to which a portion of each facility's fee revenue is allocated for redistribution to the less well-off health facilities. More experience and country-specific adaptations will be necessary to determine which local level (e.g., health facility, district, province) is appropriate for what responsibility under cost recovery programs.

QUESTION 11: How do quality improvements affect costs and financing policy?

IN BRIEF: Quality improvements increase utilization, willingness to pay fees, and revenues—but they also increase costs. The net effect depends on specific local circumstances. Appropriate financing and cost-containment policies can help to keep the lid on costs. With the current focus on medicine availability as a prime indicator of quality in Africa, the interactions between quality improvements and cost bear watching.

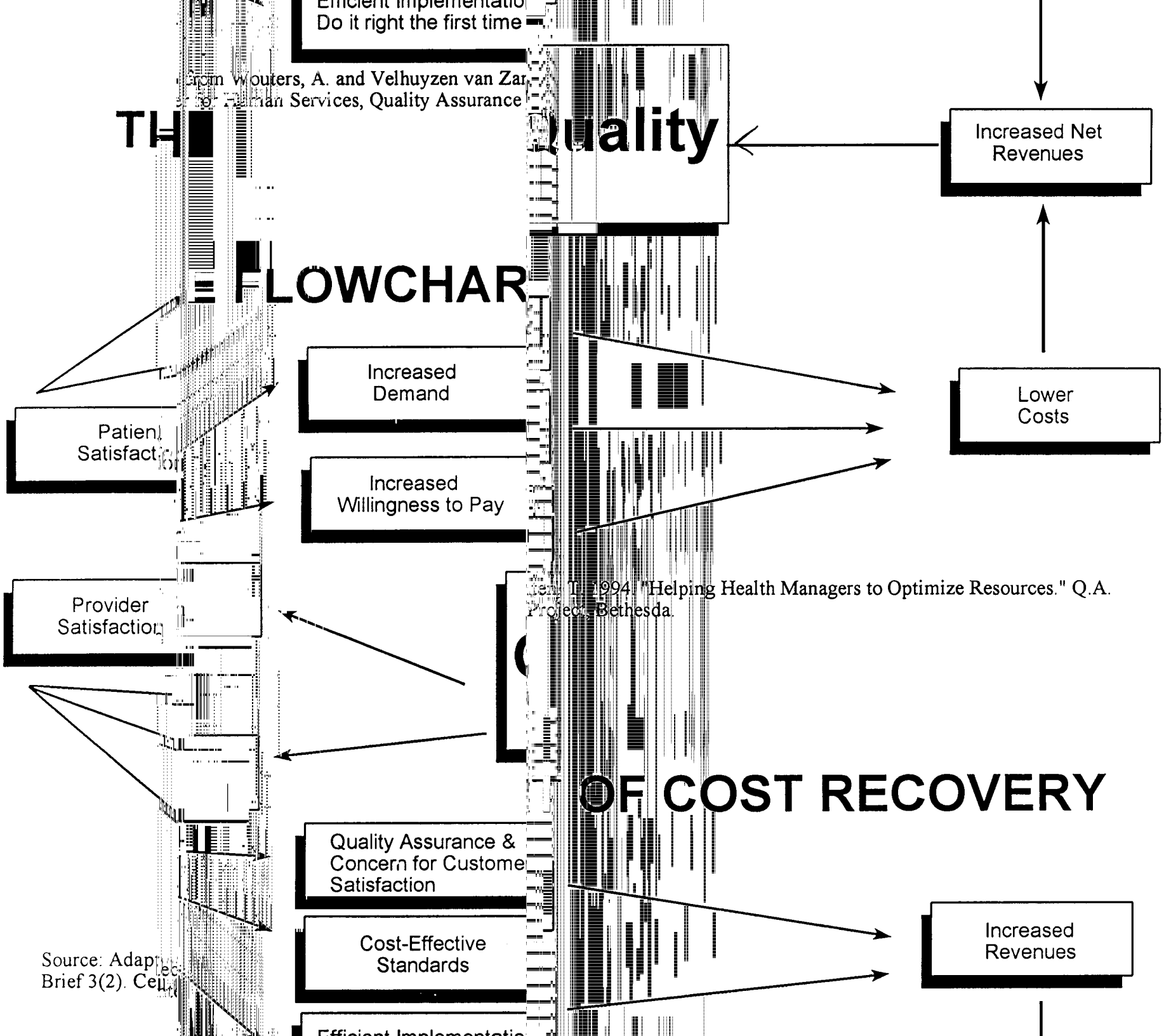
How are quality, cost, and financing linked?

Few African health ministries adequately fund the costs of essential drug supplies or other needed quality improvements (e.g., health worker training in drug prescription protocols, protocol development, drug distribution networks and inventory systems, health worker supervision and in-service training in diagnostic and treatment practices.) Filling these funding gaps has inspired many cost recovery efforts in African health systems. But little research to guide reform has been done into the complex interactions between quality and costs and effective approaches to financing the costs.

Quality improvements may help to generate additional revenues, but their effects on costs, hence net revenues, are not well known. The cost recovery and quality flowchart *(Figure 3-1)* illustrates some of the important interrelations between quality, costs, and financing. Net revenues depend on two financial flows:

1. costs to providers of quality improvements (*the bottom path*)
2. revenues generated from patients' willingness to pay for quality improvements (*the upper path*).

The combination of increased revenues and controlled costs generates an increase in net revenues which can be channeled back into further improvements. Not all quality improvements lead to increased net revenues, but this model can be used to test the connections between different approaches to cost recovery and quality improvement.[40]



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OF COST RECOVERY

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Human Services, Quality Assurance

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What implications do quality improvements have for financing policy?

The costs of quality improvements have at least two implications for cost recovery reforms and financing policy. First, because increased use due to quality improvements raises total costs, plans must be made to meet costs of a larger drug supply and other medical supply and administrative expenses directly associated with increased utilization. These variable costs must either be recovered through user fees or government must plan on budget increases to cover them.

If revenues from user fees do cover variable costs, then MOH budgets can be redirected to paying for quality improvement expenses that remain constant regardless of volume (fixed costs), especially those that enhance the cost effectiveness of the health sector.

Second, the costs associated with improving quality and utilization must be controlled to yield a net increase in revenues. A surplus from user fees can be spent to make further improvements or to reduce the need for public subsidies. Current emphasis on drug availability as the prime quality improvement illustrates this point. *(See the box below*)

QUALITY IMPROVEMENTS, DRUG AVAILABILITY, AND COST CONTAINMENT

With the current emphasis in Africa on medicine availability as the prime quality indicator, ministries of health could easily have to double or triple their spending on medicines. As drugs become available, utilization usually increases, and more drugs than ever are needed. This cycle could tax MOH budgets *unless* drug and related inventory and distribution costs are recovered through user fees. Some initiatives in Africa have recovered 100 percent of these costs.[38] In other cases, full cost retrieval may require higher fees than government wants to charge.

One way of improving quality and containing drug costs is to improve efficiency in drug-prescribing practices. Also, assuring an adequate stock of essential, generic drugs simultaneously reduces costs relative to brand name drugs, improves effectiveness of health personnel, attracts patients to the facility, increases their willingness to pay for services, and improves worker productivity by increasing the number of patients treated. Thus, appropriate drug policies are likely to be among the single most important policy actions that could simultaneously improve quality, efficiency, effectiveness, and financial sustainability of health care in Africa.

To tap peoples' willingness to pay for health services, ministries of health need reliable ways of measuring patient satisfaction with specific aspects of quality. At the same time, these ministries need to expand popular notions about what constitutes quality and their capacity to assess other dimensions. Sophisticated consumers are one of the best protections against a drug-skewed, financially strapped health system.

QUESTION 12: How do fees affect access to health care?

IN BRIEF: Fees play a less important role than once thought in determining people's use of health care under cost recovery programs in sub-Saharan Africa. When other factors affecting demand for health services are taken into account, the modest fees usually charged create much less of a barrier to utilization than may have been expected, especially in the case of primary and preventive care services. Equally and sometimes more significant obstacles are distance and poor quality. People accustomed to paying private sector fees may save money under public cost recovery programs.

Do fees deter people from using needed health care services?

Introducing or increasing fees at government facilities represents a price increase and, unless other changes are made, is likely to reduce the number of government services patients seek. But price is only one of several important factors that determine whether or not people seek health care and whether they seek care from government or other health providers. Time and travel costs, perceived quality, perceived benefit, income, education and cultural factors also influence their decisions.

Empirical evidence on the impact of fees under cost recovery reforms is hard to sort out because of the complex interaction of all these factors and methodological difficulties. But evidence is building up from Africa's experience with cost recovery that suggests that factors other than fees — especially perceived quality and geographic access (as measured by distance from the health facility) — have a stronger impact on utilization.[6,9,10,21,27] *(See Questions 4 and 9)*

> In six African countries (Cameroon, Gambia, Niger, Sierra Leone, Sudan, and Zaire), improved quality has more than offset price effects of user fees, resulting in net increases in utilization of health services. [5,7,9,21,28,29]

> In a project in Cameroon, the probability that a sick person would visit a government clinic was 25 percent higher when fees were charged and quality improvements were also made.[21]

> In a pilot test of cost recovery in Niger, initial visits increased 40 percent overall, and initial plus follow-up visits increased by 70 percent in one district. Among the poor, the utilization rate doubled. In another pilot test district, utilization held constant, but it declined in the control district where no cost recovery or quality improvements were made. In both test districts, geographic access was more important than fee levels in determining people's use of services. [8,44]

What do decreases in use mean?

After an initial decline, utilization sometimes regains previous levels. For example, in Lesotho after a fee increase and declines of between 40 percent and 51 percent in use, patient traffic regained pre-fee increase levels in most areas. Similar rebounds in utilization were reported in the Gambia, Ghana, Swaziland, and Zaire, although it is not known if utilization regained previous levels.[7,29,32,36,45]

Decreases in traffic at government health facilities after the introduction of user fees does not always signal an absolute drop in use of health services. Some patients may switch to private providers. In Lesotho, for example, an initial decline at government facilities was accompanied by a utilization increase of between 19 percent and 35 percent at private facilities. In Swaziland, a drop in utilization was partially offset by increased use of mission facilities which reportedly lowered their prices.[27,45]

User fees are sometimes deliberately used to redirect patients from over-utilized hospital-based services to appropriate and less costly services at lower levels.(*See Question 17)* Excessive use of medicines can be deliberately curtailed for quality reasons.[3,4,27]

How can a fee system cost users less than a "free care" system?

Not all "free care" is without cost to users.[1,9] People often spend large sums for travel to health facilities and for food for relatives who are hospitalized. "Free" government services are costly if low quality prompts patients to forego treatment or resort to expensive, sometimes distant private health providers or pharmacies. In Cameroon and Niger, for example, user fee systems save people money, especially the poor. People spent less of their own money on health care at government facilities than they had under the official "free care" system. In Cameroon, the most savings came from reduced time and travel costs. In Niger, households that used the improved services at government health facilities saved 50 percent over what they had previously spent on each episode of illness.[9,21,40]

Do fees discourage use of preventive services?

This is an important question, but there is too little evidence to answer it conclusively. Sub-Saharan Africa offers few examples of cost recovery programs that impose fees for preventive services where this question has been evaluated. What evidence does exist, however, suggests that people are often willing to pay for some preventive services and that at least *token* fees may not inhibit use of these services. There is also evidence that people undervalue services provided free of charge.[13,23,27]

> In 1990, more than half of 79 countries surveyed had some method of raising revenue for immunizations under the Expanded Program on Immunization (EPI), and 15 percent reported that people sought vaccinations from private providers where they paid fees.[25]

> In a pilot test in Niger, use of prenatal care increased by 10 percent after the introduction of fees and quality improvements for curative care.[43]

- In Burkina Faso, cultural factors and distance from the health facility had a stronger impact on use of immunization than did fees.[2]

- Many programs for social marketing of contraceptives have demonstrated people's willingness to pay for family planning services.

QUESTION 13: Does cost recovery reduce equity? Do fees always hurt the poor?

IN BRIEF: Charging people who can afford to pay fees for health services and providing fee relief for the poorest people improves equity compared with "free care" health systems. When used to improve quality at public health facilities, user fees can save time and money for the poor compared with free-care policies that leave health facilities without sufficient funds for good care. In these cases, the poor benefit even more than the better-off who often already have access to a wider range of health care. Specific evidence about the impact of cost recovery on the poorest people is limited, however, since most studies do not distinguish adequately among socioeconomic groups.

Can user fees be reconciled with equity?

Compared with "free care" systems, cost recovery programs can improve equity by charging people who can afford health services and using public monies for subsidies to people who cannot afford to pay. When government provides health services free-of-charge to all, many non-poor households use services they could pay for and crowd out the poorest from care they could receive.

> In Tanzania, patients from highest income households represented 35 percent of the inpatient load and 37 percent of outpatients at "free" government-run hospitals. Patients from the poorest households represented only 16 percent of inpatients and 9 percent of outpatients at these hospitals. In a separate study, 60 percent of highest income households, expressed willingness to pay fees of Tsh200 (approximately $1.00) or more if drugs would always be available at the public hospitals.[1,27]

> In Nigeria, half of the highest income households used free or highly subsidized public clinics and hospitals. Highest income households were also five times more likely to use private hospitals (25 percent) as were poorest households (5 percent), a clear indicator of willingness and ability to pay private fees.[27,39]

Inequities for the poor could often be redressed by improving the administration of fee collection and exemption systems. For example, civil servants and members of the military frequently receive exemptions from payments owed under their government employee health plans although they are better able to pay than many others. Students and friends and relatives of hospital personnel, whether or not better-off than paying patients, also receive fee exemptions. When government health plans do not reimburse public hospitals and health centers for services delivered to civil servants and similarly exempt groups — a common practice — the government, in effect, subsidizes these groups with general tax revenue that is designated for health services for the broader population. These practices also use up government resources that could be allocated to improve access for lower income households.

Do user fees hurt the poor more than the better-off?

The cost of health care is likely to be harder to absorb for the poor than the non-poor and may present the poor with an insurmountable obstacle to seeking services. Poor households not only have less cash than better-off households. They are less likely to be able to borrow funds to pay for health care and more likely to have to sell their assets to pay for a major illness.

Evidence about the impact of health service fees on the poor, and on the poorest compared with the better-off, is inconclusive, however. Many studies that look at the effect of fees on utilization neither distinguish among income groups nor take account of other changes that might affect use of health services. The few studies that have looked at these impacts by income level—for example, in Côte d'Ivoire, Kenya, Cameroon, and Niger—suggest that the poor are more sensitive than the non-poor to changes in the quality and the time-price of care, but not necessarily to prices as represented by user fee levels.[9,10,11,21,27]

Fees for health services are often among the smallest components of health care costs in African countries, especially for primary care. Even when health services in public facilities are nominally free, people spend substantial sums for health care. These other costs can be higher for the poor than the non-poor because of longer distances and higher travel costs to facilities, greater reluctance to miss work, and quality deficiencies at public health facilities that do not have user fees or reliable government funding. Poor patients are likely to suffer more than non-poor patients when clinics run out of drugs because they either go without medication or spend scarce time and money traveling to other, frequently expensive drug sources.

Modest user fees that make better and less costly services available than alternative private sources of health care can only benefit, and not harm, the poor. Policies that reduce travel or waiting time are more likely to raise utilization rates for the poor more than for the non-poor.

> In Cameroon and in Niger, after the introduction of health care fees, drug stocks improved. Not only did use rise more for the poor than the non-poor, but it also rose more for people living farthest from the health facilities.[9,21]

> In Tanzania, only 4 percent of the lowest income households said they would not pay fees for government health services if drugs were always available. Twice as high a proportion (8 percent) of highest income households were unwilling to pay fees for improved government services—perhaps because the better-off already have better access to alternative sources of care.[1]

> In Niger and the Central African Republic, the lowest income households were as willing to pay higher fees to maintain drug supplies in public health facilities as higher income households. In the Central African Republic, rural households were more willing to pay higher amounts to assure availability of medicines for priority diseases than were urban households, which had greater accessibility to health services and medicines.[9,34]

Does this mean that government need not be concerned about the impact of health care fees on the poorest households?

No. It means that ministries of health need to make greater efforts to distinguish among income groups in designing and evaluating cost recovery programs. Even in the world's poorest countries, there are differences among income groups that the national averages mask. User fees at the levels usually charged have not proven to be major barriers to use of health care for a large majority of the population in sub-Saharan Africa. But the poorest people will need protection against the additional impact of user fees, especially for inpatient hospital stays, on what are often already high costs of health care.*(See Questions 14 and 15)*

Protection against user fees will not alone solve problems of access for the poor. Improving equity of access to health care for the poor will also require removing or compensating for non-monetary barriers — distance, education, culture, quality perceptions — that pose an equal or greater obstacle than fees for service.

QUESTION 14: Are there effective and affordable ways to protect the poor when cost recovery reforms are introduced?

IN BRIEF: Policies that protect the poor and other target groups vary in both cost and likelihood that they can be administered effectively in African settings. Trade-offs exist in targeting programs between accuracy and cost. At some point, accuracy could be improved — but at greater cost — reducing the amounts available for providing services to the poor. More field experience and testing is needed to find cost-effective approaches to protecting the poor under cost recovery.

What is targeting and how does it work?

Targeting policies can be designed to protect the poor and other high-risk groups in systems where fees are charged. Targeting can take several forms, identifying people by:

- individual means testing based on income or indicators of income
- group characteristics (age, gender, occupation, infectious or chronic disease condition)
- geographic location (region, city or country, specific neighborhood)
- self-selection (everyone who goes to a specified place for a free service).

Individual means testing is the best way to identify who is "poor," and therefore eligible for reduced prices or free care, and who is not. Depending on how individual means testing is administered, however, it can also be the most costly targeting method. For example, means tests that require wage, earnings, income, or tax records are more expensive to administer than informal identification by a health worker in a small community. Both methods cost more to administer than geographic targeting, under which everyone in a certain area is automatically considered poor and therefore eligible for reduced-price or free care.

Can means testing be both accurate and affordable?

A trade-off has to be made between the cost of achieving accuracy in identifying the poor and the non-poor and the most effective methods of assuring that people are not excluded from care because of low income. The less accurate the targeting method, the more non-poor can capture the benefits or the more poor people are missed. On the other hand, money used for administrative costs of improving accuracy could be used to subsidize health services for the indigent, high-risk, or other target group. This trade-off means that the most accurate targeting mechanism is not necessarily the best. There is a point where the additional cost of administering a very accurate means testing system is higher than the cost of providing services free to some of the non-poor.[35]

What are some of the factors influencing the cost and accuracy of means testing?

Means testing costs and accuracy are influenced by a variety of factors, including population density, record-keeping capacity, and prevalence of formal employment, seasonal fluctuations in income, literacy, central registration of beneficiaries, measures to verify information, and administrative discretion in identifying applicants. Usually, it is easier to distinguish informally between people who can and cannot afford to pay user fees in small communities and at small health care facilities than in large urban areas and at large urban or district hospitals. At the same time, higher prices for hospital care than for primary health care make it more necessary to have a method for ensuring that the poorest people are not refused hospital care because of an inability to pay.

Some research has been conducted on methods that contribute to means testing accuracy and cost containment in Latin America, Africa, and Asia, but this information has not been combined to assess the relative cost-effectiveness of different approaches in any of these regions.[11,12,14,16,17,37] Other than cases in highly localized situations, models and best practices have not been documented *(See Question 15)*. Developing and testing alternative means testing and other targeting procedures for the poor, estimating their costs, and assessing their effectiveness are among the top priorities for protecting the poor under cost recovery programs.

QUESTION 15: What policies and practices are used to protect the poor in Africa?

IN BRIEF: Means testing policies and practices in Africa are usually administered locally with informally applied eligibility criteria. Informal means testing and "community solidarity" — government's most commonly used methods of protecting the poor — may be less widespread than targeting groups by non-income related criteria (e.g. civil servants, students, the military, tuberculosis patients, the handicapped). Though scanty, the evidence on effectiveness of informal means testing in Africa suggests that fee waivers are often siphoned-off to the non-poor and that many of the poor fail to receive exemptions. Ministries face key policy trade-offs between exemptions for the poor, compared with other target groups, and between revenue raising goals, compared with the economic and political need to exempt the poor and other special groups from fees.

What national policies exist and how are they applied?

Many African countries have a national policy that supports exemption of the poor from fees for health services. These policies rarely specify criteria or procedures that should be used to identify poor patients, however. About half the countries in Africa appear to have no official national policy to protect the poor from health service fees.[24]

> Only 14 documented cases of health sector means testing in Africa were located out of 56 projects using means testing in a recent survey of developing countries.[35,37]

> Surveys have identified just two countries with means testing systems specifying income cut-off levels (Zimbabwe and Ethiopia), one (Lesotho) with specific, strict criteria related to land and livestock

How effective are current practices?

While informal means testing policies — both official and unofficial — are widespread in Africa in the public and the NGO health sectors, little documented evidence exists of the effectiveness of these policies in providing fee exemptions or reductions for the poor. Reviews of country practices have concluded that means testing in African countries is limited in scope (e.g., Nigeria, Burundi, and Kenya), ineffective in practice (e.g., Uganda), or non-existent. Many constraints undermine the development and implementation of effective means testing systems in developing countries in general. Rare in African countries are "ideal" conditions for effective means testing (e.g., formal wage records, high literacy, steady income, strong administrative and information system capacities).[11,24,35]

When both fee exemption and fee collection policies are loosely administered, few people are required to pay. In such cases, it is often the non-poor who receive the lion's share of exemptions.

> Civil servants and their families in the Central African Republic before reforms were adopted received care in the central hospitals without paying their share of the bill and without government's reimbursing the facility for its share of the bill. These exemptions represented 40 percent of the inpatient hospital caseload.[34]

> Hospital patients in Mali are supposed to show a certificate of indigence to obtain a fee waiver. In practice, facility workers often waive fees without certificates, and civil servants and their families typically receive care without paying their copayment under the government health plan. In one Malian hospital these exemptions represented 70 percent of the caseload. [31]

> In Ethiopia a country where a high proportion of patients pay, exempted patients are required to go through a formal, centrally administered application process in advance of needing care.[37]

In contrast to means testing for income-related exemptions, exemptions targeted to groups based on occupation or other characteristics (e.g., civil servants, students, handicapped) are easier to administer. They are also more prevalent in African countries and likely to be more effectively applied, judging from the high proportions of exemptions reportedly granted to such groups in government health facilities.

One of the main equity issues in relation to cost recovery programs in Africa is to develop effective, administratively feasible, and low-cost methods that work as well for the poor as they do for other target groups. In doing so, ministries are likely to face trade-offs in their goals for exempting the poorest in addition to special target groups, while also trying to achieve the revenue raising goals of cost recovery. Achieving both the revenue raising and equity potential of cost recovery in sub-Saharan Africa will require finding ways to improve both fee collection and exemption practices.

How could exemption systems for the poor be improved?

Experience from targeting programs around the world suggests that health ministries can enhance their accuracy in identifying people who cannot afford to pay fees for health services by designing exemption policies with the following features:

> incentives for the administrators of the policy to give exemptions only to the truly poor, (e.g, by allowing the facility to keep fees)

> clear, formal qualification criteria, leaving administrators little leeway for exemption abuse

> periodic renewal of exemptions, exemption criteria, and payment categories

> routine measures to verify information

> local or central government involvement in the screening, registration, or verification process (instead of putting the entire burden on facilities)

> sharing of information and administrative capacity with programs that provide exemptions in other sectors

> use of other targeting methods in combination with means testing

> determination of eligibility for exemptions in advance so that uncertainty about the fee will not discourage use of health services by the poor.

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